DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC #2

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
acceptable	445294	A. BUILDING _____ B. WING _____	C 04/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF COLLEGEDALE	PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315

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F 000	INITIAL COMMENTS Investigation of Complaint (C/O) #29197, #29433, and #29515 was conducted at Life Care Center of Collegedale on April 2 - 8, 2012, and April 9, 2012. No deficiencies were cited for C/O #29197, #29433, and #29515. Observation during the investigation of the C/O's resulted in an Immediate Jeopardy cited for failure to provide supervision during mealtime. A partial extended survey was conducted on April 9, 2012. The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the Conference Room on April 9, 2012, at 2:15 p.m. The Immediate Jeopardy was effective from April 3, 2012, through April 8, 2012. Substandard Quality of Care was cited under F323-J. An Acceptable Allegation of Compliance, which removed the Immediacy of the Jeopardy, was received and corrective actions were validated on-site by the surveyor on April 9, 2012. Non-compliance of the Immediate Jeopardy tags continues at a scope and severity of a "D" level for monitoring of corrective actions. The facility is required to submit a plan of correction for all tags.	F 000	**Life Care Center of Collegedale** Preparation of and/or execution of this plan of correction does not constitute admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because of federal and state requirements. **1. CORRECTIVE ACTION** A) The resident no longer resides at the facility. **2. OTHER RESIDENTS THA T HAVE THE POTENTIAL TO BE AFFECTED** **Residents requiring supervision with dining have the potential to be affected.** On April 3rd, 2012 beginning with the dinner meal, nursing administration (Director of Nursing, Assistant Director of Nursing, RN Unit Managers, Weekend RN Supervisor, Staff Development Coordinator,	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla K Youngberg — TITLE: Administrator — (X6) DATE: 4/30/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of the facility investigation, review of facility policy, and interview, the facility failed to provide supervision and the correct dining environment for one Resident (#10) of sixteen Residents reviewed. The facility's failure to ensure Resident #10 was placed in the correct dining environment with supervision resulted in the Resident choking and aspirating food, requiring emergency rescue measures, transfer to the hospital emergency room, and admission to the Critical Care Unit on April 3, 2012, and death on April 7, 2012. The facility's failure placed Resident #10 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Resident). The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the Conference Room on April 9, 2012, at 2:15 p.m. The findings included: Resident #10 was admitted to the facility on May 3, 2011, with diagnoses including Aspiration Pneumonia, Dysphagia - Oral Phase, Dementia,	F 323	Mimimum Data Set nurses, RN Wound Nurse assured, by reviewing the tray cards that all residents were in their assigned dining areas. On April 3rd, 2012 an audit of 100% of all care plans and resident care guides was conducted by the Minimum Data Set coordinator, Registered Dietician and Unit Managers. This was completed by comparing the tray cards to the care guides and care plans to assure accuracy of resident dining assignment. On April 3rd, 2012 the Department Managers (Business Office Manager (BOM), Admissions Director, Rehab Director (RSM), Activities Director, Human Resources Director (HR), Executive Chef, Registered Dietician (RD), Maintenance Director, and Environmental Services Director) were in-serviced by the Executive Director (ED) , the Administrator in Training (AIT), and the	

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F 323	Continued From page 2 and Chronic Obstructive Airway Disease. Medical record review of Quarterly Minimum Data Set (MDS) dated February 19, 2012, revealed a Brief Interview for Mental Status (BIMS) assessment, with a score of three out of fifteen. A score of three revealed the Resident's cognition was severely impaired. Medical record review of the Physician's Recapitulation Orders dated April 1 - 30, 2012, revealed orders for a mechanical soft diet and liquids in a two-handled cup. Observation of the Resident on April 3, 2012, at approximately 1:05 p.m., in the West Day Room, revealed a meal tray was on a table directly in front of the Resident and the Resident was eating, independently and unsupervised. Continued observation at approximately 1:20 p.m., revealed the Resident was non-responsive to verbal stimuli, the body was limp, face was pale, and the lips were blue. The Resident's chest was still and then the mouth opened and closed, with a silent gasp. During the gasp a large amount of food could be seen in the Resident's mouth. Immediate observation of the West Day Room, the two West Hallways adjacent to the West Day Room, and the West Nursing Station directly across from the West Day Room revealed no staff were present and/or supervising the Resident while eating. A visitor came out into the West Hallway from a Resident's room (located between the West Day Room and the Sun Room Bistro). The surveyor informed the individual a nurse was needed immediately. As the visitor ran up the West Hallway to get a nurse, Licensed Practical Nurse (LPN) #1 came out into	F 323	Director of Nursing (DON), on dining supervision and the dining area observation schedule. The Department managers will be assigned to monitor dining and non-dining areas during dining times, for appropriate supervision of diners. On April 3rd, 2012 in-service education was provided to licensed, non-licensed and therapy staff was conducted by the Staff Development Coordinator, RN Unit Managers, Executive Chef, Administrator in Training, Director of Nursing, Assistant Director of Nursing, Rehab Manager, Admission Director and the Assistant Admissions Director, regarding code blue and supervision during dining and re-education was completed by April 11, 2012. Occupational Therapy re-screened 100% of residents on April 3rd, 2012 for amount of assistance required for dining. Any	

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F 323	Continued From page 3 the West Hallway from a Resident's room (located between rooms 319 and 323). The visitor informed LPN #1 assistance was needed in the West Day Room. LPN #1 ran to the West Day Room; the Resident was not breathing and food was spilling from the Resident's mouth. LPN #1 did a finger-sweep and removed more food from the Resident's mouth and initiated the Heimlich Maneuver (abdominal thrusts applied as an emergency response to clear an obstructed airway of a person that is choking); as LPN #1 applied abdominal thrusts, food was expelled from the Resident's mouth. LPN #2 arrived and began to assist LPN #1. With several additional abdominal thrusts, the Resident took some irregular breaths; but the breathing was not ongoing or spontaneous. LPN #1 and #2 transported the Resident to the Resident's room. The Director of Nursing began applying abdominal thrusts, and was relieved by Registered Nurse (RN) #1, who applied several abdominal thrusts. LPN #1 suctioned the Resident's mouth and obtained a small amount of food particles. Oxygen was applied to the Resident at four liters per minute using a nasal cannula; the Resident's breathing was irregular and labored. 911 had been called during the onset of the emergency; the Emergency Medical Services (EMS), arrived within minutes, assumed control of the situation, and transported the Resident to the hospital Emergency Room (ER). Review of a facility investigation dated April 3, 2012, with "lunch" in parenthesis, revealed, "...Summary of Investigative Facts: Resident found by State Surveyor choking in West Wing Day Room. Recommendations/Actions Taken: Resident given Heimlich Maneuver, 911 called,	F 323	changes were noted by obtaining physician orders, and updating the tray cards, Care Plans and Care Guides. The re-screen was completed on April 5, 2012. 3. **WHAT MEASURES WERE PUT IN PLACE** Dining Best Practice was developed on April 4th. (see attached) Beginning on April 4, 2012 and completed on April 9, 2012, licensed, non-licensed, and therapy staff were in serviced by the Staff Development Coordinator, Administrator in Training, Rehab Service Manager, Environmental Services and the Human Resources Director on The Dining Assignment Best Practice. This information was also added to the facility general orientation on April 4th. On April 5th, 2012 a list of the residents assigned dining areas was placed by the RN Unit Managers at each nurse's station in the assignment book, on the	

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F 323	Continued From page 4 transport to hospital..." Review of a written statement dated April 3, 2012, by the Assistant Activities Director, revealed, "I rolled (Resident) down to the "Day Room" on West Wing and gave (Resident) a lunch tray." Review of a written statement dated April 3, 2012, by LPN #1, revealed, "...I was coming out of a Resident room...told me someone needed me toward the day room, the lady that I knew to be from the State, said I was needed...(Resident) was at table and appeared to be choked, had food coming out of mouth, appeared not to be breathing. Started Heimlich, got food out of mouth, pt (Patient) took breath, done Heimlich several more times, got food out...took some breaths...took Resident to room...suctioned Resident, got small amount of food out..." Review of a written statement dated April 3, 2012, at 3:50 p.m., by LPN #2, revealed, "...I was in the office on West Wing charting when I overheard someone repeatedly calling a resident's name. I came out of the office and saw LPN #1 trying to get the Resident to wake up. I immediately ran over and assisted...Resident was pale...tongue sticking out...unresponsive..." Review of a written statement dated April 3, 2012, at approximately 1:21 p.m., by the Assistant Director of Nursing (ADON), revealed, "...I quickly ran down hallway to (Resident's) room...DON (Director of Nursing) was performing the Heimlich Maneuver. (Resident) was not breathing, pale, and blue around the lips, radial pulse felt and it was steady...LPN #1 began suctioning (Resident)...placed oxygen at four	F 323	med carts, and in each dining area. On admission/readmission the residents will be screened by the DON/designee for appropriate dining room placement. Health Information Management Coordinator (HIM), will update the Dining Checklist with new admissions and discharges based on the Diet Communication form completed on admission by nursing. Current residents will have any change in dining location communicated by the RN Unit Manager to the HIM department, MDS and the RD using the Dietary Communication form. The Weekend Supervisor will be responsible for updating the Dining Checklist on the weekends and holidays. On April 5th 2012, a Dining Room Checklist was initiated to verify placement of residents assigned to each area. Licensed nurses were in-serviced by Nursing Administration on the use of a checklist for	

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F 323	Continued From page 5 liters...continued Heimlich...began breathing spontaneously, unable to obtain oxygen saturation (the amount of oxygen bound to hemoglobin in the blood, with the normal range being 95-100%) (percent), fingers would not read on either hand. (Resident) began to moan, but no verbal speech...EMS arrived and took over..." Review of the Diet Tray Card, dated April 3, 2012, revealed the Resident's required dining location was "2nd (second) Dining (supervised dining area)." Review of the facility policy "Hydration and Nutrition" dated as revised October 2008, revealed, "...Policy: Nursing staff are assigned to each unit dining room at mealtime to provide supervision of residents while eating...Procedure:...4. An ongoing assessment of ability to consume and assimilate food and fluid by resident is conducted by nursing personnel. Assessment includes:...c. Ability of resident to feed self. d. Ability to chew, drink, and swallow..." Medical record review of a Resident Transfer Record, dated April 3, 2012, (no time) revealed, "...Transferred From: (Nursing Home)...Reason for Transfer: Aspirated on lunch - unresponsive..." Medical record review of the Emergency Department (ED) Admission Orders dated April 3, 2012, at 3:17 p.m., revealed, "...ICU (Intensive Care Unit)...Diagnosis: Aspiration Pneumonia - Ventilator Pt..." Medical record review of a Pulmonary/CCU (Critical Care Unit) Progress Note, dated April 3, 2012, at 3:30 p.m., revealed, "...began choking on	F 323	each dining area to verify that each resident is in their assigned dining area. Beginning on April 6th, 2012 RN Unit Managers began verifying and documenting that Dining Checklists had been completed by the nurse assigned to the dining area daily. On April 5th and April 9th all Care Guides and Care Plans were updated by the MDS Coordinator with dining area assignments and assistance required. To ensure staff has a clear understanding of the Dining Best Practice, a questionnaire was created and on April 23, 2012, staff was randomly chosen to complete daily for 14 days. **4. MONITORING** On April 4th a Performance Improvement meeting was held with the Director of Nursing, Executive Director, facility management and the Medical Director.	

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F 323	Continued From page 6 lunch today, semi-responsive upon EMS arrival, intubated in the field. Continued review on April 4, 2012, at 8:20 a.m., revealed, "...Pt s/p (status post) episode of aspiration (Nursing Home)...intubated en route to ER by EMS..." Medical record review of a Triage Report, dated April 3, 2012, at 4:17 p.m., revealed, "...Complaint: Choking/Aspiration...Triage Notes: Pt choking during lunch, semi-responsive upon EMS arrival, intubated in the field...History of Present Illness:...pt choked during lunch...MD (Medical Doctor) Physical Exam: Pt is intubated...peas are currently being removed...Diagnosis: Aspiration Pneumonia s/p choking episode..." Medical record review of a History - Physical Examination, dated April 3, 2012, at 4:29 p.m., revealed, "...brought to the emergency room...intubated...resides at (Nursing Home) and apparently aspirated mostly on peas...the patient was brought to the emergency room and remains intubated on the ventilator and apparently there was quite a bit of food matter that was suctioned through the endotracheal tube...Assessment and recommendations:...aspirated while eating and was intubated for respiratory distress..." Medical record review of portable Chest Radiology Reports revealed the following: April 3, 2012; "...Volume loss right upper lobe, question some endobronchial plugging versus early Pneumonia..." April 4, 2012: "...Clearing right upper lobe infiltrate..." April 5, 2012; "...Status-post extubation with mild Bibasilar Atelectasis..."	F 323	Discussed was the concern, and education. The Dining Best Practice and the audit process were approved at this meeting. The RN Unit Managers will verify and document Monday through Friday that the Dining Checklist has been completed by the nurse assigned to the dining area. The RN Supervisor and/or Weekend Manager on Duty manager will complete this task on the weekend and holidays. The audit tools will be completed by the RN Unit managers/ Weekend RN supervisor daily for 14 days, and weekly for 12 weeks. The Director of Nursing will report the findings of the dining audit compliance to the Performance Improvement Committee monthly for 3 months. The Executive Director will audit the RN Unit Managers documentation weekly for 12 weeks, and report the findings of this Oversight Audit to the	

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F 323	Continued From page 7 April 6, 2012; Minimal interstitial infiltrate, primarily in the right upper lobe, superimposed on chronic disease..." Medical record review of a Pulmonary/CCU Progress Note, dated April 4, 2012, at 8:20 a.m., revealed, "...Pt s/p episode of aspiration..." Continued review on April 5, 2012, at 8:21 a.m., revealed, "...Pt s/p aspiration with food...resulting in respiratory failure...may have had some level of anoxic injury during episode of aspiration...consider hospice or palliative care." Continued review on April 6, 2012 at 1:30 p.m., revealed a Hospice consult, "...patient will be admitted...upon transfer out of CCU to the Hospice Unit..." Medical record review of a Death Record Form dated April 7, 2012, and telephone interview with the Hospital's Release of Information Coordinator on April 12, 2012, at 12:30 p.m., revealed the Resident expired on April 7, 2012, at 8:01 a.m. and a Discharge Summary had not been dictated yet. Interview with the Administrator on April 3, 2012, at 1:40 p.m., in an empty Resident room across from the North Nursing Station, confirmed the Resident was assigned to eat all meals in the second dining, located in the Bistro Sun Room. Continued interview confirmed the resident required supervision during all meals. Interview with LPN #2 on April 3, 2012, at 1:50 p.m., at the West Nursing Station, confirmed, "...Residents are not to be eating in the (West) Day Room because there's no supervision there...(LPN #2) was in an office behind the West	F 323	Performance Improvement Committee monthly for 3 months. The Performance Improvement Committee (ED, DON, Medical Director, Social Service Director, Environmental Service Director, HR, Activity Director, RD, Executive Chef, Maintenance Director) will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and /or the audits reviewed for three months or until 100% compliance is achieved.	COMPLETION DATE April 26, 2012

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Nursing Station...(LPN #2) confirmed...was not watching the Resident eat...I don't know if I could have seen (Resident)...from where I was sitting..." Continued interview confirmed the Resident did require supervision while eating.

Interview with LPN #3 on April 3, 2012, at 2:00 p.m., at the North Nursing Station confirmed, "... (Resident) is a second diner in the Bistro Sun Room...requires assistance or to be fed at meals...requires supervision during meals..."

Interview with the DON on April 3, 2012, beginning at 2:20 p.m., in the Administrator's Office, and continued in the DON's Office, confirmed, "Resident's are not supposed to eat in the West Wing Day Room due to the lack of supervision. (Resident) eats in the second dining Bistro Sun Room."

Interview with RN #2 on April 3, 2012, at 2:40 p.m., in the Conference Room confirmed (Resident) was assigned to the second dining in the Bistro Sun Room for meals. Continued interview confirmed (Resident) had cognitive deficits, required supervision during meals, and was not to be placed in the West Day Room unsupervised for meals.

Interview with the Assistant Activities Director on April 3, 2012, at 3:00 p.m., in the Conference Room confirmed the Assistant Activities Director placed the Resident in the West Day Room for lunch, put the lunch tray on the table in front of the Resident to eat, and left. Continued interview confirmed the Assistant Activities Director did not check to make sure staff was in the West Day Room to supervise the Resident's meal, and did

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not recall any staff present in the West Day Room to supervise the meal.

Interview with Speech Language Pathologist (SLP) #1, on April 3, 2012, at 3:45 p.m., by telephone, confirmed Residents assigned to eat in second dining in the Bistro Sun Room required assistance and supervision to eat safely and efficiently.

Interview with SLP #2, on April 3, 2012, at 4:05 p.m., in the Conference Room confirmed, "...It is not acceptable to place a Resident assigned to second dining that required supervision in an unsupervised area for meals; it is not safe."

Interview with CNA #1, on April 3, 2012, at 6:00 p.m., on the North Hall near the North Nursing Station confirmed the Resident is to be taken to the second dining in the Bistro Sun Room, and stated, "(Resident #10) is not able to eat by (Resident's) self."

Interview with LPN #4, on April 3, 2012, at 6:07 p.m., at the North Nursing Station confirmed the Resident eats second dining in the Bistro Sun Room, and stated, "(Resident) does require supervision during meals for safety and a decline in cognition."

A second interview with the Assistant Activities Director, in the presence of the DON, on April 4, 2012, at 11:50 a.m., in the Conference Room confirmed, "...I put (Resident) in the West Day Room for lunch...I went to the second dining in the Bistro Sun Room and got the (Resident's) lunch tray from the tray cart, took it to the West Day Room and placed it in front of (Resident) and

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left...I knew (Resident) was assigned to and ate in second dining in the Bistro Sun Room...and the tray ticket says "second dining"...I don't know why I put (Resident) there...I don't have a clue why I did it."

Interview with CNA #2 and #3, on April 4, 2012, at 12:00 p.m., in the Bistro Sun Room, confirmed (Resident) was assigned to eat all meals in the second dining in the Bistro Sun Room.

Interview with the DON on April 4, 2012, at 12:10 p.m., in the Bistro Sun Room confirmed, "(Resident) is assigned to the second dining in the Bistro Sun Room because of poor cognition, which does not enable her to make safe decisions." Continued interview with the DON confirmed the facility failed to provide supervision for safety in the correct dining environment for the Resident.

In summary, the facility failed to ensure Resident #10 was placed in the Bistro Sun Room for second dining with supervision during lunch on April 3, 2012, resulting in the Resident choking and aspirating food substances, requiring emergency rescue measures, transfer to the hospital emergency room, admission to the Critical Care Unit, and death on April 7, 2012.

The Immediate Jeopardy was effective from April 3, 2012, through April 9, 2012, and was removed April 9, 2012. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyor through review of documents, staff interviews, and observations conducted onsite on April 9, 2012. The surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445294	A. BUILDING _____ B. WING _____	C 04/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF COLLEGEDALE	PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 verified the allegation of compliance by: 1. Reviewing the corrective action implemented for the Assistant Activities Director. 2. Reviewing the facility's plan for ensuring Residents are supervised and in the correct dining room. Reviewing the facility's plan for auditing the dining environments to ensure staff is following the plan. Reviewing the facility's in-service records to ensure facility staff have been educated regarding changes to and implementation of the facility's policies "Dining Assignment Best Practice," and "Resident Dining Changes." 3. Conducting interviews with facility staff, to include eight of thirteen nurses, three of nine environmental services, one of two maintenance, two of four activities, one of two social services, nine of twenty-one CNA's, on staff to determine the level of comprehension gained through in-service education conducted regarding changes to and implementation of the facility's policies "Dining Assignment Best Practice," and "Resident Dining Changes" for transporting residents to the correct dining room; supervision of dining and non-dining areas during meals; ensuring correct dining placement upon admission, re-admission, and change of condition. 4. Observation of the dining and non-dining areas during meals to ensure staff supervision and correct dining room placement of the Residents. Non-compliance continues at a "D" level for	F 323		

MAY 0 1 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12 monitoring corrective actions. The facility is required to submit a plan of correction.	F 323		COMPLETION DATE April 26, 2012

LIFE CARE CENTER OF COLLEGEDALE

DINING ASSIGNMENT BEST PRACTICE

1. Each nursing unit will send Licensed Nurses/Certified Nursing Assistant (C.N.A.) staff to dining rooms based on assignment located on the daily staffing sheet. Licensed Nurses and C.N.A.s, Licensed Therapist and/or department managers (Business Office Manager, Admission Director, Health Information Management Coordinator, Activities Director, Human Resources Director, Executive Chef, Registered Dietician, Social Services Director, Environmental Services Director, Maintenance Director, and Executive Director), are responsible to transport residents to dining areas.

2. The nurse and C.N.A. staff will remain in the dining room until the meal is complete.

3. To provide for resident safety, dining and non-dining areas will be supervised by assigned department managers or as assigned by the administrator in the absence of the department manager. For weekend coverage the Manager on Duty and the RN House Supervisor will monitor dining and non-dining areas.

4. All residents are to eat in their assigned dining areas unless otherwise approved by the Director of Nursing, Assistant Director of Nursing, RN Unit Managers, RN Staff Development Coordinator, RN House Supervisor, RN Charge Nurse. If a resident refuses to participate in the dining room, the resident will be observed one on one by a Licensed Nurse. C.N.A., Licensed Therapist until their meal is complete. The RN House Supervisor will ensure this on the weekends.

5. The DON or RN House Supervisor, or RN Unit Managers, in order to determine appropriate dining placement, will screen residents on admission, readmission, and change of condition. Weekend coverage will be provided by the RN House Supervisor, they may also consult the nurse on call.

6. After admission, on Monday-Friday during normal working days, the interdisciplinary team which includes (Director of Nursing or Assistant Director of Nursing, Occupational Therapist or Speech Therapist, RN Unit Manager, Dietician or Executive Chef), will assess all new admissions to determine level of assistance needed. This assessment will include the Rainbow Program, amount of assistance required, history, Occupational and/or Speech therapy assessment, and nursing input. The Rainbow Program is a cognitive assessment completed by the Rehab department. The RN House Supervisor completes the screen for new admission/ re-admissions on the weekend to determine appropriate dining placement.

7. Once the best dining location has been confirmed, the dining location will be noted in the following areas: Care Guide (located on the C.N.A. clipboard, Care Plan (located in the resident chart) , Diet/Tray Card (located on the resident meal tray), Medication Record Book, the Assignment Book on each unit and the Dining Room Checklist (located in each dining room on a clipboard)